THE FOOT AND ANKLE CARE CENTER, INC.

MEDICAL INFORMATION Height ____ Weight___

Shoe Size_______

PATIENT NAME:____

PLEASE PROVIDE BRIEF DESCRIPTION OF THE NATURE OF ILLNESS/INJURY & PRIOR TREATMENTS:

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HOW LONG HAVE YOU HAD THIS CONDITION?_______________________________

DATE OF INJURY:____________________(if applicable)

PHARMACY INFORMATION:_______________________________

ALLERGIES:_______________________________

CURRENT MEDICATIONS:_______________________________

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems

- ❑ Asthma
- ❑ Bleeding or clotting disorder
- ❑ Cancer
- ❑ Chest pain
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Shortness of Breath
- ❑ Stroke
- ❑ Weakness/Numbness in extremities
- ❑ Other: (please specify)_____________ ______________________________

PAST SURGERIES: If yes, please list all prior operations with dates

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PAST SOCIAL HISTORY:

	YES	NO	If Yes, How Often?
Tobacco use:	____	___	_________________
Alcohol use:	____	___	_________________
Drug use:	____	___	_________________
Exercise regularly	____	___	_________________

If yes to Exercise, list the types of exercise and how much

____

____

____

FAMILY HISTORY: Any illness that runs in the family?

If yes, please list

____

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Signature:_________________________ Date:_____________________